

Attendance of children and adolescents with psychoactive substance use disorders performed by Psychosocial Care Centers in Brazil, 2008-2012*

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Déborah Santos Conceição¹ –  orcid.org/0000-0002-7905-1964

Sérgio Baxter Andreoli²

Monique Azevedo Esperidião¹

Darci Neves dos Santos¹

¹Universidade Federal da Bahia, Instituto de Saúde Coletiva, Salvador, BA, Brasil

²Universidade Federal de São Paulo, Departamento de Psiquiatria, São Paulo, SP, Brasil

Abstract

Objective: to describe the profile of care for children and adolescents with psychoactive substance use disorders performed by the Brazilian Psychosocial Care Centers (Centros de Atenção Psicossocial - CAPS) from 2008 to 2012. **Methods:** a descriptive study with data from the SUS Outpatient Information System (Sistema de Informações Ambulatoriais do Sistema Único de Saúde - SIA/SUS) and the system of National Registration of Health Establishments (Cadastro Nacional de Estabelecimentos de Saúde - CNES). **Results:** a total of 151.330 attendances were observed, 81.2% were males and 99.2% were in the age range of 10 to 19 years; the main causes were polydrug use (56.7%), cocaine (15.6%), marijuana (15.6%) and alcohol (9.0%); the CAPS for Alcohol and other Drugs (CAPS AD) accounted for 81.8% of the records; from 2008 to 2012, the attendance rate from 39.6 to 76.7/100 thousand inhabitants. **Conclusion:** there was an increase in the attendance rates, observing the predominance of males, age range of 10 to 19 years and disorders due to polydrug use.

Keywords: Child; Adolescents; Substance-Related Disorders; Mental Health Services.

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Correspondence:

Déborah Santos Conceição – Universidade Federal da Bahia, Instituto de Saúde Coletiva, Rua Basílio da Gama, s/n, Campus Universitário, Canela, Salvador, BA, Brasil. CEP: 40110-040
E-mail: deborah.santosc@yahoo.com.br

Introduction

The disorders arising from the consumption of psychoactive substances, together with other mental disorders accounted for 13.0% of the global burden of disease in 2013.¹ Worldwide, in the year 2010, 7.4% of years of life lost adjusted for incapacity (Disability-Adjusted Life Years – DALY) and 22.9% of those lived with disability (Years Lived with Disability – YLD) took place in the consumption of these substances, and the abuse and dependence among the 20 leading causes of severe and moderate disability, overcoming the conditions related to malnutrition, worms, asthma and amputations.^{2,3}

Approximately 5% of the world population aged 15 to 64 years reported use of any psychoactive substance in the year 2015, it is estimated that 0.6% had problems related to this use, regardless of age, sex, education and income and that only one in every six people would have access to some specialized service for treating this kind of dependency.⁴

In the period from 1990 to 2013, the smoking and alcohol use were among the greatest risks to the health of adolescents and the psychoactive substance use is responsible for more than 3.1% of years of life lost adjusted for incapacity in the population from 10 to 24 years of age.

In the last decade, studies of global coverage, the example of the Global School-Based Student Health Survey (GSHS) and the Health Behavior in school-aged Children (HBSC), highlight the earliness and the intense use of some substances.^{5,6} In the period from 1990 to 2013, the smoking and alcohol use were among the greatest risks to the health of adolescents and the psychoactive substance use is responsible for more than 3.1% of years of life lost adjusted for incapacity in the population from 10 to 24 years of age.⁷

According to the National Adolescent School-based Health Survey (Pesquisa Nacional da Saúde do Escolar - PeNSE), performed with students of the 9th year of elementary education in public and private schools in Brazil, experimentation with alcohol and tobacco occurred with greater frequency to 13 years of age,

with a prevalence of lifetime use exceeding 15% for tobacco and above 50% for alcohol use; the first use of illicit substances is observed between 14 and 15 years, with a prevalence of 9%.⁹

The model of care for people with needs related to psychoactive substance use is based on the comprehensiveness of care, action planning and risk reduction and damage.^{10,11} The Psychosocial Care Centers (CAPS) are specialized services of strategic importance for the reception of persons with mental disorders and/or needs relating to the consumption of psychoactive substance. Among the CAPS, highlights the Psychosocial Care Centers Alcohol and Other Drugs (CAPS AD), specialized in the attendance of people with needs arising from the use of these substances.¹²

The literature on the consumption of psychoactive substance in childhood and adolescence focuses on the analysis of the consequences harmful to health, being scarce the production of studies that allow an increased understanding of the phenomenon and address health care. Show necessary Systemic and complex approaches centered on the recognition of the specificities of these periods of life and the possibilities for reception, binding and listens to the height of the relevance of the theme in the national and international scenarios.^{6,12,13}

Considering the (i) low research on health care directed at children and adolescents with needs arising from the consumption of psychoactive substances and (ii) the importance of characterizing the profile of treatment, this study aims to describe the profile of treatment for children and adolescents with mental and behavioral disorders arising from the use of psychoactive substances performed by Psychosocial Care Centers in Brazil, in the period from 2008 to 2012.

Methods

Descriptive study, using secondary data from the Ambulatory Care Information System of the Brazilian National Health System (Sistema de Informações Ambulatoriais do Sistema Único de Saúde - SIA/SUS) and the system of National Database on Health Units (Cadastro Nacional de Estabelecimentos de Saúde - CNES) available on the website of the IT Department of SUS (Departamento de Informática do SUS - Datasus).

The Authorization of Outpatient Procedure (Autorização de Procedimento Ambulatorial - APAC) is the document

that identifies each user and ensures prior authorization and proper recording of services that have been rendered, as outpatient procedures members of SIA/SUS. The record of individualized attendance, procedures and treatments carried out in health establishments is done in APAC, allowing the decentralized processing such data production.

The data relating to health care in the CAPS began to be included in the spreadsheet of SIA/SUS in 2002; however, the detailing of the information of the attendances was deficient and restricted to the indication of age and cause of care. Only in the year 2008 was the inclusion of other demographic information, allowing a better characterization of attendances. From 2013, the record of attendances and procedures performed on CAPS began to be done in the Registry of Outpatients Actions of Health (Registro das Ações Ambulatoriais de Saúde - RAAS), replacing the registry in APAC. The present study included data throughout the period in which there was detailing the demographic characteristics and diagnostic of health care and procedures performed on CAPS with record in APAC.

The National Database on Health Units (CNES) provides information on establishments, health professionals, sources sponsors and registration of teams of health establishments. The CNES includes all hospitals linked or not to the SUS, all outpatient establishments providers of services to SUS and private establishments that perform procedures. For all that, the CNES is considered an instrument for planning, control and evaluation of SUS.

For a description of the characteristics and the spatial distribution of CAPS, we used data from the CNES (session 'Reports', option 'qualifications'). The CAPS were identified and classified according to the following subtypes:

- CAPS I - serves people of all ages with serious and persistent mental disorders and also with needs arising from the use of psychoactive substances, in municipalities with populations between 20 thousand and 70 thousand inhabitants; runs from 08:00 to 18:00 hours, on workdays;
- CAPS II - serves the same audience and presents operation similar to CAPS I, capable of extending until 21:00 hours, in municipalities with a population of over 70 thousand inhab.;
- CAPS III - for municipalities with a population of over 200 thousand inhabitants, with continuous attention

and daily during 24 hours, including public holidays and weekends;

- CAPSi - with operation similar to CAPS II, serves children and adolescents with mental disorders and also with needs arising from the use of psychoactive substances, in municipalities with a population of around 150 thousand inhabitants;
- CAPS AD - with operation similar to CAPS II, serves people of all ages with needs arising from the use of psychoactive substances, in municipalities with a population exceeding 70 thousand inhab.;
- CAPS AD III - serves the same audience of CAPS AD, with operation at the 24 hours of the day, shall be in the proportion of one for each population group of 200 to 300 thousand inhabitants.

The data of the CNES were organized in spreadsheets, guided by the software Microsoft Office Excel 2007, selecting the establishments per subtype and excluding those enabled after 2012.

For demographic characterization and diagnosis of treatment, we used the data from APAC. It was downloaded the files disseminable for tabulation of SIA/SUS outpatient production type, organized and available for free per year, unit of the federation (FU) and month.

The APAC data were extracted and decompressed using the tabwin program version 10. Data were also organized by the Excel application 2007, unified monthly per year and FU, observing the municipality and comparing the codes of establishments authorized in the CNES with codes of establishments registered in APAC.

A group of variables mentioned the establishment of health: location (municipality and FU); year of enabling (2008 to 2012); and type of CAPS (CAPS I; CAPS II; CAPS III; CAPSi; CAPS AD/CAPS AD (III)). Another group of variables was adopted for the health care: year in which occurred the attendance (2008 to 2012); age (in years: less than 1 year; 1 to 4; 5 to 9; 10 to 14; 15 to 19); sex (male and female); ethnicity/skin color (white; black, brown, yellow; indigenous people; without information); and the cause of attendance (according to the International Statistical Classification of Diseases and Related Health Problems - 10th revision ICD-10: F10 to F19).

To verify the reliability of the data, we observed inconsistencies in the diagnoses assigned to the age of 5 years - signs of clinical and physical and psychological complications, dependency syndrome, abstinence syndromes, amnesic syndrome, psychotic disorders

and other disorders not consistent with this age group, which led to the exclusion of these observations.

Rates from assisting children and adolescents with mental disorders by use of psychoactive substances were calculated by FU and great national region, adopting as numerator the number of health care from people in the age up to 19 years and as denominator the resident population of the same age, multiplied by 100 thousand.

The analysis of the temporal evolution of the health care was performed using the percentage variation ($\Delta\%$) of rates at the beginning (T_i) and end of the period (T_f), calculated by the following formula:

$$\Delta\% = \left(\frac{T_f - T_i}{T_i} \right) \times 100$$

The software Stata version 12 and Microsoft Office Excel 2007 were used in these procedures.

According to the principles of Resolution of the National Health Council (Conselho Nacional de Saúde - CNS) No. 510, of 7 April 2016, the study did not use information permitting the identification and/or to cause damage to individuals whose data were analyzed, not requiring, therefore, authorization of Committee for Ethics in Research (Comitê de Ética em Pesquisa - CEP).

Results

We observed the 5,565 municipalities existing until 2012, although only 1,406 had CAPS; they were found 1,898,821 records whose 'mental and behavioral disorders by the use of psychoactive substances' represented cause of care. The exclusion of visits not performed on CAPS resulted in 1,860,509 records. After verification of the age and exclusion of those above 19 years, remained 152,833 records of attendance.

Finally, with the exclusion of observations are inconsistent, the study considered 151,330 treatment for children and adolescents with mental and behavioral disorders arising from the use of psychoactive substances (Table 1).

The male sex predominated among the attendances: 81.2% of records. At the age range from 15 to 19 years was responsible for 84.0% of treatment, followed by the age of 10 to 14 years, with 15.2%. Minors of 10 years contributed with 0.8%. The lack of information on the variable ethnicity/skin color corresponded to 45.4%. The ethnicity/skin color white was indicated

in 29.1% of records, followed by brown, with 19.6%, and black, with 4.8%. The ethnicity/skin color yellow contributed only 1.0% and the indigenous, with less than 0.1% (Table 1).

The mental and behavioral disorders due to use of multiple psychoactive substances were responsible for 56.7% of records, being the first cause of care. Disorders due to the use of cocaine and mental disorders by use of cannabinoids were the second cause of care, with 15.6%. Mental disorders by use of alcohol showed a percentage of 9.0% while the disorders related to the use of other SPA (Psychoactive substances) contributed with 3.1% (Table 1).

Each year of the period studied, the mental disorders by use of multiple psychoactive substances remained as the first question to answer. Those arising from the use of cannabinoids were the second cause of care in the years 2008, 2009 and 2012, with frequencies of 14.3%, 15.2% and 17.2%, respectively. In the years 2010 and 2011, the disorders by the use of cocaine came to occupy the second position, with percentages of 16.6% and 18.0%, respectively. The mental disorders by use of alcohol were the fourth leading cause of service throughout the period, being indicated in 11.0% of records in 2008, 11.1% in 2009, 8.7% in 2010, 7.6% in 2011 and 8.2% in 2012 (Table 1).

The analysis according to the type of CAPS indicated that 81.8% of the health care were carried out by CAPS AD and 10.4% by CAPSi. The CAPS III showed the lowest contributions, less than 0.5%. The CAPS AD remained the highest frequencies in all regions. In the Northeast, Southeast and South regions, the CAPSi occupied the second position, contributing, respectively, with 9.4%, 10.1% and 14.3% of attendances. The North and Midwest, differentiated by the contribution of CAPS I: in these regions, the number of health care made by the CAPS I surpassed that of health care by CAPSi, occupying the second position in the ranking of health care by type of CAPS (Table 2).

The national attendance rate amounted to 39.6 cases per 100 thousand inhabitants in 2008 to 76.7 cases per 100 thousand in 2012, with a positive variation of 93.7%. The South and Southeast regions topped the volume of attendances. The first presented the highest rates throughout the period studied, with 103,6/100 thousand inhabitants in 2008 and 160,1/100 thousand inhabitants in 2012. The second began the period with the rate of 33,1/100 thousand inhabitants, reaching

Table 1 – Demographic Characteristics and nosological of attendance for children and adolescents with mental and behavioral disorders by use of psychoactive substances performed in Psychosocial Care Centers, Brazil, 2008-2012

Variables	Year										Total	
	2008		2009		2010		2011		2012		n	%
	n	%	n	%	n	%	n	%	n	%		
Sex												
Female	3,941	19.4	4,131	17.5	5,490	17.8	6,755	18.1	8,081	20.7	28,398	18.8
Male	16,501	80.7	19,531	82.5	25,412	82.2	30,580	81.9	30,908	79.3	122,932	81.2
Age group (in years)												
5-9	256	1.2	201	0.8	219	0.7	298	0.8	213	0.5	1,187	0.8
10-14	3,540	17.3	3,879	16.5	4,783	15.5	5,200	13.9	5,608	14.5	23,010	15.3
15-19	16,646	81.4	19,582	2.8	25,900	83.8	31,837	85.3	33,168	5.1	127,133	4.0
Ethnicity/skin color												
White	6,835	33.4	7,105	30.0	8,083	26.2	10,434	27.9	11,584	29.7	44,041	29.1
Black	1,136	5.6	1,145	4.8	1,482	4.8	1,741	4.7	1,828	4.7	7,332	4.8
Brown	4,245	20.8	4,353	18.4	5,373	17.4	7,381	19.8	8,268	21.2	29,620	19.6
Asian	274	1.3	284	1.2	264	0.8	261	0.7	448	1.1	1,531	1.0
Indigenous	9	0.0	5	0.0	3	0.0	22	0.1	30	0.1	69	0.0
No information	7,943	38.9	10,770	45.5	15,697	50.8	17,496	46.9	16,831	43.2	68,737	45.4
Cause of attendance												
F10 ^a (alcohol)	2,242	11.0	2,620	11.1	2,699	8.7	2,849	7.6	3,207	8.2	13,617	9.0
F11 ^b (opioid)	80	0.4	76	0.3	86	0.3	123	0.3	182	0.5	547	0.4
F12 ^c (cannabinoids)	2,924	14.3	3,600	15.2	4,455	14.4	5,870	15.7	6,729	17.2	23,578	15.6
F13 ^d (sedatives)	62	0.3	51	0.2	92	0.3	120	0.3	53	0.1	378	0.2
F14 ^e (cocaine)	2,511	12.3	3,284	13.9	5,145	16.6	6,721	18.0	6,026	15.5	23,687	15.6
F15 ^f (stimulants)	150	0.7	49	0.2	71	0.2	151	0.4	181	0.5	602	0.4
F16 ^g (hallucinogens)	29	0.1	50	0.2	51	0.2	226	0.6	70	0.2	426	0.3
F17 ^h (tobacco)	258	1.3	186	0.8	262	0.8	312	0.8	321	0.8	1,339	0.9
F18 ⁱ (solvents)	470	2.3	294	1.2	255	0.8	197	0.5	161	0.4	1,377	0.9
F19 ^j (multiples SPA ^k)	11,716	57.3	13,452	56.8	17,786	57.6	20,766	55.6	22,059	56.6	85,779	56.7
Total	20,442	13.5	23,662	15.6	30,902	20.4	37,335	24.7	39,119	25.8	151,330	100.0

a) F10: Mental and behavioral disorders due to use of alcohol.

b) F11: Mental and behavioural disorders due to use of opioids.

c) F12: Mental and behavioural disorders due to use of cannabinoids.

d) F13: Mental and behavioral disorders due to the use of sedatives and hypnotics.

e) F14: Mental and behavioral disorders due to use of cocaine.

f) F15: Mental and behavioral disorders due to use of other stimulants, including caffeine.

g) F16: Mental and behavioral disorders due to the use of hallucinogens.

h) F17: Mental and behavioral disorders due to use of tobacco.

i) F18: Mental and behavioral disorders due to use of volatile solvents.

j) F19: Mental and behavioral disorders due to use of multiple drugs and the use of other psychoactive substances.

k) SPA: Psychoactive Substances.

Sources: Authorization for outpatient procedures (APAC); International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10).

94,2/100 thousand inhabitants at the end of the period. All regions showed growth of attendance rates with larger percentage variations in the Southeast - 184.8% and 151.6% Midwest (Table 3).

Acre, Paraná and Paraíba led the attendance rates in 2008, presenting values of 182,9/100 thousand inhab., 139,4/100 thousand inhab. And 121,2/100

thousand inhab., respectively. At the end of the period, the Paraná remained with high attendance rates, 190,7/100 thousand inhab., being accompanied by Mato Grosso - 204,5/100 thousand inhab. - and São Paulo - 148,4/100 thousand inhab. Above reductions of 80.0% were observed in the rates of Acre, Distrito Federal and Paraíba. It was not possible to estimate

Table 2 – Distribution of records of attendance due to mental and behavioral disorders by use of psychoactive substances, according to type of Psychosocial Care Center and great national region, Brazil, 2008-2012

Type of CAPS	Region										Total	
	North		Northeast		Southeast		South		Midwest			
	n	%	n	%	n (63,165)	%	n	%	n	%	n	%
CAPS I ^a	210	5.7	2,098	7.4	981	1.5	2,416	5.3	307	2.8	6,012	4.0
CAPS II ^b	98	2.7	417	1.5	4,645	7.3	215	0.5	7	0.1	5,382	3.6
CAPS III ^c	6	0.2	176	0.6	222	0.3	17	0.0	95	0.9	516	0.3
CAPSi ^d	39	1.7	2,664	9.4	6,380	10.1	6,482	14.3	129	1.2	15,694	10.4
CAPS AD ^e / CAPS AD III ^f	3,322	90.4	22,973	81.1	50,937	80.6	36,245	79.9	10,249	95.0	123,726	81.8
Total	3,975	100.0	28,328	100.0	63,165	100.0	45,375	100.0	10,787	100.0	151,330	100.0

a) CAPS I: Psychosocial Care Center type I.

b) CAPS II: Psychosocial Care Center type II.

c) CAPS III: Psychosocial Care Center type III.

d) CAPSi: Psychosocial Care Center for Childhood and Youth.

e) CAPS AD: Psychosocial Care Center for Alcohol and other Drugs.

f) CAPS AD III: Psychosocial Care Center for Alcohol and other Drugs 24 Hours.

Sources: Authorization for outpatient procedures (APAC); National Database on Health Units (CNEIS).

the percentage variation between Amazonas, Roraima and Amapá (Table 3).

In the analysis according to age range, the largest attendance rates were presented by the adolescent population from 15 to 19 years (Table 4). Considering the cause of attendance and age range, the mental disorders by use of multiple psychoactive substances maintained the highest rates throughout the period, except for 5 to 9 years age group in which they were overcome by health care to mental arising from the use of alcohol in the years 2009 and 2012, with 0.4 health care/100 thousand inhabitants. (Multiples SPA) versus 0.5 health care/100 thousand inhabitants. (Alcohol) Table 5). At the age of 5 to 9 years, presented a positive variation of the mental disorders by use of opioids, cannabinoids, hallucinogens and tobacco. At the age range from 10 to 14 years presented a negative percentage variation only for mental disorders by use of solvents, there is reduction of 73.7% in attendance rates for this cause. The range of 15 to 19 years exhibited a negative variation for mental disorders by use of sedatives and solvents, with a reduction of 35.1% and 54.6%, respectively (Table 5).

Discussion

In the present study, the male sex was indicated in most of the records, as well as the age of adolescence (10-19 years). Stood out as major causes of attendance, the mental and behavioral disorders through the use of multiple psychoactive substances use disorders, by

the use of cocaine, marijuana and alcohol. There was a constant growth in the number of health care in CAPS, with large variations of attendance rates between the Federative Units and major national regions.

The increase may be related with the expansion of the health care network and greater acceptance of the demands associated with the use of psychoactive substances. According to the Ministry of Health, between the years of 2006 and 2011, programs directed to the confrontation of the consumption of these substances have expanded the provision of care through the incorporation of technology of care for 24 hours, represented mainly by the CAPS AD III and CAPS III, and by the expansion of specific services for children and adolescents.¹⁴

The variation of the frequencies and rates from assisting among the national macro regions can reflect inequalities in the distribution of the CAPS by country. Only 62.2% of municipalities considered eligible for deployment of CAPS come with the service. Verifying their distribution by region, the North has the lowest percentage, with CAPS in only 47.7% of the municipalities are eligible, and the southern region the most high, with 70.0% of its municipalities offering such services.¹⁴

It is supposed that the attendance rates in Brazil were affected by structural inequalities related to differences in income between the FU and regions, organization and access to network services, as well as the quality of the records submitted.

The predominance of treatment for male subjects reflects a global trend. It is estimated that

Table 3 – Evolution of attendance rates (per 100 thousand inhabitants) for children and adolescents with mental disorders by use of psychoactive substances, according to Region and Federative Unit (FU), Brazil, 2008-2012

Region/FU	Year															Δ%		
	2008			2009			2010			2011			2012					
	Fem	Male	Total	Fem	Male	Total	Fem	Male	Total	Fem	Male	Total	Fem	Male	Total	Fem	Male	Total
North	3.6	264.7	13.0	2.2	7.6	9.2	2.7	21.5	12.3	4.5	32.0	18.5	6.7	27.7	17.4	82.7	-89.5	33.8
Rondônia	0.0	0.3	1.4	2.9	74.7	5.3	6.3	30.5	18.6	3.4	23.8	13.8	16.5	59.1	38.3	22,021.1	2,577.4	
Acre	59.4	148.7	182.9	22.2	0.0	48.8	5.7	61.8	34.1	13.6	122.0	68.5	10.3	40.2	25.5	-82.6	-73.0	-86.1
Amazonas	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.1	0.0	2.3	1.1	0.2	3.7	2.0			
Roraima	0.0	0.0	0.0	0.0	18.7	0.0	0.0	0.0	0.0	1.3	0.0	0.6	5.1	26.8	16.2			
Pará	1.8	240.4	8.6	0.8	0.0	9.9	2.3	21.3	12.0	5.9	37.6	22.2	6.5	27.1	17.0	266.0	-88.7	98.3
Amapá	0.0	0.0	0.0	0.0	35.3	0.0	2.5	5.0	3.8	6.6	68.1	37.6	6.5	52.6	29.7			
Tocantins	0.0	8.7	2.3	6.6	16.0	21.2	8.5	65.9	37.6	4.7	32.5	18.8	13.6	43.0	28.5	394.8	1,119.0	
Northeast	10.7	49.0	30.1	11.9	59.0	35.8	11.9	64.8	38.8	13.1	65.7	39.8	12.1	61.9	30.1	13.2	26.3	0.1
Maranhão	5.7	37.8	22.0	3.5	33.9	18.9	5.7	45.3	25.8	9.8	86.3	48.6	8.2	85.4	47.4	43.8	126.0	116.1
Piauí	34.4	110.2	72.9	21.7	85.0	53.9	19.4	100.0	60.4	16.3	75.7	46.5	22.1	97.1	60.2	-35.7	-11.9	-17.4
Ceará	11.9	69.7	41.3	15.5	76.2	46.4	14.6	71.0	43.3	15.3	65.4	40.8	11.5	40.1	26.0	-3.2	-42.5	-36.9
Rio Grande do Norte	5.4	21.4	13.5	6.1	17.7	12.0	7.3	29.7	18.7	12.3	41.7	27.3	8.3	48.4	28.7	52.2	126.5	111.9
Paraíba	51.0	189.6	121.2	46.7	209.5	129.1	45.7	214.5	131.2	28.8	204.8	117.9	31.3	183.8	0.1	-38.7	-3.1	-99.9
Pernambuco	9.7	40.1	25.1	11.0	52.4	32.0	10.3	64.7	37.9	13.6	48.7	31.4	14.6	58.7	37.0	49.8	46.4	47.1
Alagoas	2.8	14.8	8.9	5.1	28.4	16.8	3.1	23.6	13.4	2.9	31.7	17.4	0.6	20.3	10.6	-78.4	37.2	19.0
Sergipe	2.3	64.5	33.7	6.2	53.6	30.1	9.4	68.6	39.3	16.9	91.3	54.4	12.4	79.0	46.0	441.7	22.6	36.4
Bahia	1.8	10.3	6.1	7.2	38.7	23.3	7.7	42.6	25.5	10.6	37.6	24.3	9.3	36.2	23.0	426.2	250.1	274.8
Southeast	13.4	52.1	33.1	13.0	59.3	36.5	25.7	104.0	65.6	35.2	143.2	90.2	42.2	144.1	94.2	215.6	176.8	184.8
Minas Gerais	13.8	41.1	27.7	8.9	50.3	30.0	14.5	71.9	43.8	14.6	73.8	44.8	15.2	72.7	44.5	9.9	76.8	60.6
Espírito Santo	10.4	56.9	34.1	8.7	69.6	39.7	8.0	34.3	21.4	13.3	41.6	27.7	14.4	22.5	18.6	38.7	-60.4	-45.6
Rio de Janeiro	3.1	11.4	7.3	3.6	18.6	11.2	8.8	35.3	22.3	19.4	73.9	47.1	14.0	51.8	33.3	354.7	355.6	355.8
São Paulo	17.3	72.4	45.3	18.9	78.2	49.0	39.2	152.3	96.8	53.3	213.1	134.7	68.7	225.1	148.4	296.4	211.0	227.4
South	43.5	161.3	103.6	47.5	195.4	123.0	48.7	210.7	131.4	53.1	233.8	145.3	62.3	253.9	160.1	43.4	57.4	54.6
Paraná	68.0	208.2	139.4	68.1	217.0	144.0	64.8	228.4	148.2	65.2	282.1	175.8	78.1	298.9	190.7	15.0	43.6	36.8
Santa Catarina	26.1	119.6	73.8	29.1	152.6	92.2	37.2	185.7	113.0	44.7	204.0	126.1	49.1	230.8	141.9	88.3	93.0	92.2
Rio Grande do Sul	28.3	137.4	83.9	37.0	198.7	119.5	38.8	207.5	124.9	45.3	200.9	124.8	53.7	220.3	138.8	90.1	60.4	65.4
Midwest	12.2	51.7	32.2	15.1	78.6	47.4	19.6	94.7	57.8	25.2	106.0	66.3	47.1	113.9	81.1	287.6	120.4	151.6
Mato Grosso do Sul	11.7	34.8	23.5	16.8	49.0	33.3	12.2	67.4	40.5	8.6	75.5	42.9	10.1	66.0	38.7	-13.1	89.5	64.9
Mato Grosso	11.0	41.9	26.8	20.3	129.6	76.2	37.4	109.7	74.4	79.4	189.9	135.9	146.0	260.5	204.5	1226.2	522.2	663.6
Goiás	18.0	84.1	51.7	18.1	95.5	57.5	21.5	135.1	79.4	13.8	114.1	65.0	31.3	103.8	68.2	73.5	23.5	32.1
Distrito Federal	0.0	0.3	0.2	0.0	0.0	0.0	0.6	2.1	1.4	2.1	8.8	5.4	0.0	0.0	0.0	-100.0	-100.0	
Brazil	15.5	62.9	39.6	16.3	74.6	46.0	21.8	97.4	60.3	26.9	117.6	73.1	32.4	119.4	76.7	108.4	90.0	93.7

Notes:
 Fem: attendance rate for persons of the female sex.
 Male: attendance rate for males.
 Overall: attendance rate not standardized by sex.
 Δ%: percentage variation of the attendance rate.

in 2015, one in each three people who consumed psychoactive substances belonged to the female sex; however, only one out of every five in treatment are women.⁴ the stigma related to the abusive use of

such substances among women stands out among the access barriers hindering the recognition of the existence of problems related to the use and the consequent search for treatment.¹⁵

Table 4 – Attendance rates for children and adolescents with mental disorders by use of psychoactive substances (per 100 thousand inhabitants), according sex and age range, Brazil, 2008-2012

Variables	Year					Δ% ^a
	2008	2009	2010	2011	2012	
Sex						
Female	15.5	16.3	21.8	26.9	32.4	108.4
Male	62.9	74.6	97.4	117.6	119.4	90.0
Age group (in years)						
5-9	1.5	1.2	1.3	1.8	1.3	-13.3
10-14	20.6	22.5	27.8	30.2	32.6	58.4
15-19	96.6	113.9	15.1	185.6	193.5	100.2
Cause of attendance						
F10 ^b (alcohol)	4.3	5.1	5.3	5.6	6.3	45.2
F11 ^c (opioid)	0.2	0.1	0.2	0.2	0.4	131.0
F12 ^d (cannabinoids)	5.7	7.0	8.7	11.5	13.2	133.7
F13 ^e (sedatives)	0.1	0.1	0.2	0.2	0.1	-13.2
F14 ^f (cocaine)	4.9	6.4	10.0	13.2	11.9	143.7
F15 ^g (stimulants)	0.3	0.1	0.1	0.3	0.4	22.5
F16 ^h (hallucinogens)	0.1	0.1	0.1	0.4	0.1	145.1
F17 ⁱ (tobacco)	0.5	0.4	0.5	0.6	0.6	26.3
F18 ^j (solvents)	0.9	0.6	0.5	0.4	0.3	-65.2
F19 ^k (multiples SPA ^l)	22.7	26.1	34.7	40.7	43.4	91.2
Total Rate^m	39.6	46.0	60.3	73.1	76.7	93.7

a) Δ%: percentage variation of the attendance rate.

b) F10: Mental and behavioral disorders due to use of alcohol.

c) F11: Mental and behavioural disorders due to use of opioids.

d) F12: Mental and behavioral disorders due to use of cannabinoids.

e) F13: Mental and behavioral disorders due to the use of sedatives and hypnotics.

f) F14: Mental and behavioral disorders due to use of cocaine.

g) F15: Mental and behavioral disorders due to use of other stimulants, including caffeine.

h) F16: Mental and behavioral disorders due to the use of hypnotics.

i) F17: Mental and behavioral disorders due to use of tobacco.

j) F18: Mental and behavioral disorders due to use of volatile solvents.

k) F19: Mental and behavioral disorders due to multiple drugs use and use of other psychoactive substances.

l) SPA: Psychoactive Substances.

m) Total Rate: attendance rate standardized total.

Sources: Authorization for outpatient procedures (APAC); International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10).

The predominance of attendance in individuals with increased age may be related to greater access and consumption of these substances with increasing age. Studies with population of adolescents in Brazil, Spain, Colombia and the United States of America have similar results, indicating that the increase of age is accompanied by an increase in the supply and consumption of psychoactive substances.^{8,16-18}

It is worth mentioning that the criteria for the diagnosis of mental and behavioral disorders by the use of psychoactive substances have as reference to the adult population, there are limitations to its application in children and adolescents. Points out that inconsistencies in studies directed to this younger population and divergences between the

main diagnostic manuals used in the bring confusion for the definition of the tables presented, there is no clear distinction between levels of involvement of the life of the individual and/or severity of consumption.

The higher frequency of health care resulting from disorders due to the use of multiple psychoactive substances can indicate a higher frequency of combined use of psychoactive substances - whose diagnosis should occur only in cases in which the substances consumed are chosen chaotic and indiscriminate manner, or when there is no clarity of the contributions of different drugs.¹⁹

These findings point to the need for more specific studies on the consumption of psychoactive substances by children and adolescents. Despite recurring research the type of substance consumed, there is

little information on how it is used, there is evidence of an increase of the combined use of alcohol and other substances (such as energy, marijuana and medications) for Brazilian students, in addition to the growth in the number of hospitalizations arising from the use of multiple substances, according to a survey conducted in 27 state capitals in the country.^{20,21}

Even though, in the total population of Brazil, the use of alcohol has been, in 2013, responsible for more than 90% of deaths due to mental disorders due to the use of psychoactive substances, health care by this question contributed with only 9.4% of records analyzed.¹⁴ assuming that the frequency of consumption of a given substance is associated positively with the frequency of health care, arising from the use of the same substance, the results found here diverged - even partially - of the literature on the consumption of psychoactive substances in children and adolescents. In spite of the substances most consumed by this population are alcohol, tobacco and marijuana, the mental disorders by use of tobacco not ranked among the major causes of attendance, and those arising from the use of alcohol occupied the fourth position.^{8,16,22}

It is suggested that between the effects of drug prohibition is a concern with the possible abuse of psychoactive substances lawful, since the classification between licit and illicit substances is arbitrary, not possessing criterion related to possible risks and damage to health. Thus, the losses are attributed mainly to illicit substances, while those related to licit substances are not considered, which can affect the search for care and treatment.²³

Observing the public policies on drugs and health in Brazil, it is emphasized that, in the period analyzed here, there was an increase in policies to combat the use of cocaine smoked (crack), a possible explanation for the growth of health care to the population that consumes such substance.²⁴

Also noteworthy is that more than 80% of the analyzed records came from CAPS AD and CAPS AD III. In the year 2012, there were 172 CAPSi, of which 114 (66%) registered treatment for children and adolescents with mental disorders by use of psychoactive substances, while the 294 CAPS AD/AD III, 281 (96%) attended by children and adolescents with these disorders.

Table 5 – Attendance rates for children and adolescents with mental disorders by use of psychoactive substances (per 100 thousand inhabitants), according to the attendance and age range, Brazil, 2008-2012

Cause of attendance	Year / age																	
	2008			2009			2010			2011			2012			Δ% ^a		
	5-9	10-14	15-19	5-9	10-14	15-19	5-9	10-14	15-19	5-9	10-14	15-19	5-9	10-14	15-19	5-9	10-14	15-19
F10 ^b (alcohol)	0.5	2.7	9.8	0.5	3.2	11.6	0.3	3.3	12.1	0.0	3.1	12.9	0.5	3.0	15.3	-5.1	9.2	55.9
F11 ^c (opioid)	0.0	0.1	0.3	0.1	0.1	0.2	0.0	0.2	0.3	0.1	0.2	0.5	0.1	0.3	0.6	299.7	211.7	86.8
F12 ^d (cannabinoids)	0.0	3.6	13.3	0.0	4.6	16.3	0.0	6.0	19.8	0.1	7.2	26.9	0.1	7.6	31.5	247.5	110.2	136.4
F13 ^e (sedatives)	0.0	0.1	0.3	0.0	0.1	0.2	0.0	0.3	0.3	0.0	0.3	0.4	0.0	0.1	0.2	-100.0	69.2	-35.1
F14 ^f (cocaine)	0.1	1.7	12.7	0.1	2.4	16.7	0.1	2.6	27.3	0.0	3.8	35.3	0.0	3.2	31.9	-80.5	81.4	150.8
F15 ^g (stimulants)	0.2	0.3	0.4	0.0	0.1	0.1	0.0	0.1	0.3	0.0	0.4	0.5	0.0	0.5	0.6	-100.0	47.2	54.4
F16 ^h (hallucinogens)	0.0	0.0	0.2	0.0	0.0	0.3	0.0	0.0	0.3	0.5	0.4	0.4	0.1	0.0	0.3	838.3	300.0	104.8
F17 ⁱ (tobacco)	0.0	0.3	1.2	0.1	0.3	0.7	0.0	0.4	1.1	0.0	0.3	1.5	0.0	0.5	1.4	4.3	80.0	13.4
F18 ^j (solvents)	0.1	1.5	1.2	0.1	0.8	0.8	0.1	0.8	0.6	0.1	0.5	0.6	0.0	0.4	0.5	-90.5	-73.7	-54.6
F19 ^k (multiples SPA ^l)	0.5	10.3	57.2	0.4	10.9	66.9	0.7	14.1	88.8	0.4	14.1	106.6	0.4	17.0	111.2	-18.2	65.9	94.2
Total Rate^m	1.5	20.6	96.6	1.2	22.5	113.9	1.3	27.8	15.1	1.8	30.2	185.6	1.3	32.6	193.5	-13.3	58.4	100.2

a) Δ%: percentage variation of the attendance rate.

b) F10: Mental and behavioral disorders due to use of alcohol.

c) F11: Mental and behavioural disorders due to use of opioids.

d) F12: Mental and behavioral disorders due to use of cannabinoids.

e) F13: Mental and behavioral disorders due to the use of sedatives and hypnotics.

f) F14: Mental and behavioral disorders due to use of cocaine.

g) F15: Mental and behavioral disorders due to use of other stimulants, including caffeine.

h) F16: Mental and behavioral disorders due to the use of hypnotics.

i) F17: Mental and behavioral disorders due to use of tobacco.

j) F18: Mental and behavioral disorders due to use of volatile solvents.

k) F19: Mental and behavioral disorders due to multiple drugs use and use of other psychoactive substances.

l) SPA: Psychoactive Substances.

m) Total Rate: attendance rate standardized total.

Sources: Authorization for outpatient procedures (APAC); International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10).

The disorders observed is confined to those presented by children and adolescents. Notwithstanding, the CAPSi present difficulties to meet your audience age group in their needs related to the consumption of SPA, directing this demand for specific treatment of abuse of without considering the specificities of age and possible limitations of the CAPS AD in the attention of the population of adolescents.

North and Midwest regions showed the lowest frequencies of health care in the CAPSi, reflecting the scarcity of this type of CAPS in these regions. Data on the distribution of these services revealed that these regions accounted for less than 10% of CAPSi existing in the year of 2014; the states of Acre, Roraima and Tocantins even had this service, showing the fragility of the provision of care for children and adolescents with mental and behavioral disorders.

The present study has limitations inherent to the use of secondary data, whose quality is not possible control. The completion of the filling regarding ethnicity/skin color was unsatisfactory, not allowing adequate analysis of this variable.

Data relating to the health care of minors of 10 years were interpreted with caution. Although the literature does not point restrictions regarding age, in relation to the diagnosis of disorders arising from the consumption of psychoactive substances, it is questioning about the plausibility of early ages already exhibit the demonstrations required to receive such a diagnosis.¹⁹ Thus, it is assumed the incorrect filling of some data, possibly originated from inadequate record of age or diagnosis.

The data used are relating to health care in the CAPS. Thus, it can be performed more than one answer for the same user, causing its characteristics were counted more than once. The findings of this study suggest the need for expansion and qualification of the provision of care to people with mental arising from the use of psychoactive substances. Shows it is necessary to increase the number of CAPSi and CAPS AD, measure to be accompanied to the suitability of the CAPS AD for care for children and adolescents, and greater acceptance of CAPSi the demands related to the consumption of SPA by population of children and adolescents.

The services of attention to people with needs related to the consumption of SPA can present little adequacy and difficult access by the population of children and adolescents, to consider the specificities

of these periods of life or singularities of these subjects. Many times, the access to treatment has occurred from actions directed to the Judiciary, indicating inefficiency of the health sector and/or existence of complex situations and impediments of social character. With the organization of the Psychosocial Care Network, the articulation among the different sectors can be strengthened with the guarantee of an integral attention to users of psychoactive substances.

Shows it is essential to compliance with the guidelines of the psychosocial care for children and adolescents, namely:

- Recognition of children and adolescents as subjects, also responsible for their demands and symptoms;
- Universal acceptance, as evidenced by the guarantee of care in all health services, identifying the needs and proposing the necessary interventions;
- Forwarding involved and corresponsable, through the identification of the most appropriate service and monitoring of the case until the customer takes place;
- Permanent construction of network and intersectoriality, with operations based in the territory; and
- Evaluation of shared construction demands and the needs of mental health.¹²

It is recommended that the extension of the debate on the consumption of psychoactive substances by children and adolescents, proposing and/or strengthening interventions beyond prevention, considering the current scarcity of studies on the theme. The present study sought to stimulate this debate and represents a contribution to the knowledge and planning of actions directed at the population of children and adolescents with needs related to the consumption of psychoactive substances.

Authors' contributions

Conceição DS and Santos DN contributed substantially to the conception and design of the study, data acquisition and analysis of the results, experimental and elaboration of the first version of the manuscript. Andreoli SB and Esperidião MA contributed to the interpretation of data, drafting of preliminary versions and critical review of the intellectual content of the manuscript. All the authors approved its final version and declared to be responsible for all aspects of the study, ensuring its accuracy and integrity.

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